MADRAS MEDICAL COLLEGE AND

RESEARCH INSTITUTE

CHENNAI

PSYCHOLOGY CASE RECORD

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By

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BONAFIDE CERTIFICATE

This is to certify that this is a bonafide record of the work done by **Dr. ABIRAMI.V** in partial fulfillment of the requirement for the DPM Final Examination of the Tamilnadu Dr. M. G. R. Medical University during the period June 2008 - March 2010.

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INDEX

Sl. No	Name	Age	Sex	Diagnosis	Page No.
1	Mr. S	23	M	Paranoid schizophrenia	1
2	Mrs. N	45	F	Bipolar depression	7
3	Mr. M	20	M	Obsessive-compulsive Disorder	15
4	Mrs.K	22	F	Borderline personality disorder	21
5	Mr.D	38	M	Unspecified organic mental disorder	30

PATIENT – 1

Name	:	**Mr. S**
Age	:	23 yrs
Sex	:	Male
Religion	:	Hindu
Education	:	XII standard
Marital Status	:	Single
Occupation	:	Unemployed
Socio economic	:	LSES
Informants	:	Father
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

1. Decline in academic performance - 5 yrs
2. Remaining quiet and withdrawn - 4 yrs
3. Accusing family members of trying to poison him
4. Talking to self - 3 yrs
5. Poor personal care

HISTORY OF PRESENT ILLNESS:

Mr. R, an above average student, began to fare very badly in exams during his + 2 period. He complained of inability to memorise and was often noted to be lost in thoughts. His interactions with friends and later with family members declined gradually after he discontinued his studies. He also became suspicious of his own family members, frequently argued and shouted at them for minor events and later accused them of trying to kill by poisoning his food. During daytime he was found sitting alone and muttering to himself. His self

care deteriorated and he grew a long beard; wore the same clothes for days together.

No h/o substance abuse, seizures, head injury or LOC.

No treatment to date.

PAST HISTORY:

Nil significant.

FAMILY HISTORY:

Suicide by his mother's brother - ? Impulsive.

PERSONAL HISTORY:

Full term normal delivery

Normal milestones

Above average in studies.

PREMORBID PERSONALITY

Well adjusted, no substance abuse

PHYSICAL EXAMINATION:

General examination WNL

CVS – S1, S2 heard

RS – NVBS heard

Abdomen – Soft, nontender, no organomegaly

CNS – Clinically normal.

BP – 110/70 mm Hg.

Pulse – 80/min

MENTAL STATUS EXAMINATION:

General Appearance: Patient was found wearing a shabby attire, gaze avoidance observed, rapport was established with difficulty.

Psychomotor activity normal

Talk – Decreased productivity, relevant and coherent

Affect – Constricted affect.

Thought – Persecutory delusions

Perception – III person auditory hallucinations. Commenting male voices.

PRIMARY MENTAL FUNCTIONS:

Attention aroused but poorly sustained

Memory immediate, recent and remote intact.

General information average

Calculation average

Poor abstract ability

INVESTIGATIONS:

Blood WNL

CT scan NAD.

DIAGNOSTIC FORMULATION:

23 yrs old unmarried male with 5 yrs h/o decline in academic performance, poor interaction, hostility towards family members, poor self-care, muttering, suicide by maternal uncle, MSE revealing decreased speech

productivity, gaze avoidance, constricted affect, delusions of persecution, III person auditory hallucinations commenting type.

DIAGNOSIS:

F 20.0 Paranoid Schizophrenia.

PSYCHOLOGICAL ASSESSMENT:

Mr. R is provisionally diagnosed as a case of paranoid schizophrenia. He is assessed for his personality, psychopathology and confirmation of diagnosis.

Tests administered and their rationale:

Symptom Sign Inventory

It is used to arrive at a diagnosis by rating his symptoms on various diagnostic categories.

Sentence Completion Test

It is a semi projective test used to assess his attitudes toward his self, family, friends, colleagues and superiors. It is also used to assess his attitudes towards future aims and goals in life and the possible guilt in his life.

Thematic Apperception Test

It is a structured projective test to assess his interaction, conflicts and outlook toward future.

Rorschach

It is an unstructured projective test used to assess his personality and to arrive at a diagnosis.

BEHAVIOURAL OBSERVATION:

He is cooperative for testing but is not very spontaneous or enthusiastic. He looks concerned in between and thinks for a long time in-between. He has an indifferent mood most of the time.

He has elevated scores on the dimension of paranoia and schizophrenia. Some of the paranoid items scored are feeling that his family is plotting against him, accusing him of things that he has not done and trying to harm him. Some of the schizophrenic items given by him are that of strange and unique experiences, getting confused, and confusion over thinking.

He has negative feelings towards his parents and friends as seen from Sentence completion test. He feels he is isolated in the world and no one cares for his wellbeing. He also feels overwhelmed by the hostility expressed by the world around him.

Thematic Apperception Test → His stories on TAT are brief and appear to be ordinary contents reveal themes of poverty, vengeance, interpersonal conflicts; aggression and hostility. Feeling of loneliness is expressed here and there.

Rorschach reveals that he has no clear cut concepts and clear boundaries to his responses. Poor recall ability of his responses was noted. His popular and human responses show low human interaction and his poor touch with reality. The F responses given by him depicts psychiatric process. Contents also reveal hostility and loneliness, poor ego strength and negative perception of life.

SUMMARY:

Definitive psychotic perception in Rorschach

Elevated scores on paranoia, schizophrenia on SSI.

Themes of conflicts, aggression, hostility, vengeance in TAT.

Findings favour a diagnosis of Paranoid Schizophrenia.

FINAL DIAGNOSIS:

F 20.0 Paranoid Schizophrenia.

MANAGEMENT:

PHARMACOLOGICAL --Atypical antipsychotics – Olanzapine 15 mg/day

PSYCHOTHERAPY- Distraction techniques for auditory hallucinations

OCCUPATIONAL THERAPY

PATIENT – 2

Name	:	**Mrs. N**
Age	:	45 yrs
Sex	:	Female
Marital Status	:	Married
Occupation	:	Saree sales person
Religion	:	Hindu
Education	:	10^{th} std
Socio economic	:	LSES
Informants	:	Self & Daughter
Information	:	Reliable, Adequate and Consistent

PRESENTING COMPLAINTS:

Sadness of mood
Easy fatigability
Lack of interest in pleasurable activities
Feelings of guilt
Suicidal ideas
Vague fear, palpitation,tremor
Sleep disturbance.

} 6 months

Onset :insidious

Course : episodic in nature. This is 3^{rd} episode

HISTORY OF PRESENT ILLNESS:

Patient was apparently normal 6 months back. Her family members came to know about her extra marital affair. Since then she reduced her

communication with him. She started feeling sad most of the time. She was not able to do household work as before. She felt tired very easily and wanted to lie down most of the time. She preferred being alone in a dark room. She stopped socializing much with others. She often cried and lamented about what had happened. She felt excessively guilty about what she had done. She was not able to enjoy watching TV serials and reading books as she did it before. Her appetite was reduced and she was having less quantity of food. She started losing weight.

She started having sleep disturbance in the form of difficulty in initiating sleep. She slept for about 4 to 5 hrs per day. She tried to commit suicide by hanging 20 days back. She thought of her mother who is dependent on her and didn't complete the act. She started feeling nervous and tensed. She started having palpitations and excessive fear. Hence she was brought to IMH for management.

No h/o suggestive of psychotic features

No h/o repetitive thoughts or acts

PAST HISTORY :

27yrs back, she attempted suicide by drowning in the sea.

24 yrs back, she consumed excessive tablets and she was taken to kmc and admitted there for about a week. Following this for about 6 Months she had crying spells, she was not able to do her household work herself care was Inadequate. She had sleep disturbance. These symptoms resolved Spontaneously

18 yrs back, she had possession attack after her father's death. She started behaving like her father which lasted for 3 to 4 months. Then she became normal.

1½ yrs back ,she reports being excessively happy ,spent more attention to her grooming. She started singing songs and she was able to do a lot of work. She earned more. She slept for about 3 to 4 hrs per day. Due to this, her family members became hostile towards her and that has precipitated the current episode

H/o of pulmonary tuberculosis 11 yrs back. Took ATT for 2 yrs

H/o hypertension, on irregular treatment with T.Enalapril 2.5 mg 1-0-0

FAMILY HISTORY:

Born of non consanguineous marriage

Father - died 18 yrs back by suicide (hanging)

Mother - 75 years old

H/o alcohol dependance in father and younger brother

H/o depression in his father

Patient is the 2nd order by birth & has 3 siblings. Other siblings are alive and healthy.

PERSONAL HISTORY:

Birth and developmental history could not be elicited

Average in studies. She finished X std.then she joined type writing course. She was working as saree sales person.

She attained menarche at the age of 14 yrs. She had regular periods. She would have head ache, tension, irritability, crying spells in the pre menstrual period

Married since 27 yrs.non consanguinous, arranged marriage. Marital disharmony present.

She has one daughter and one son. Both of them are alive and healthy

Sexual relationship with her husband is unsatisfactory

PREMORBID PERSONALITY

Ambivert, attached, religious, responsible.

PHYSICAL EXAMINATION:

Moderately built

Not anaemic, jaundiced

No pedal edema, lymphadenopathy, thyroid swelling

BP – 120/80 mm Hg.

PR – 80/min, regular

CVS – S_1, S_2 heard.

RS – NVBS heard.

Abdomen – Soft, non tender, no organomegaly

CNS – Clinically normal.

Fundus – Normal

MENTAL STATUS EXAMINATION:

General Appearance and Behaviour: Conscious, ambulant, In touch with surroundings. Dressed adequately, well kempt, gaze contact sustained. Co-operative, Rapport established. No tics or mannerisms.

Psychomotor activity – normal.

Talk - Quantum, Rate and Tone - normal, Reaction time normal, Relevant and Coherent.

Mood - (s) feels sad

(o) depressed

Thought – Form and stream - Normal

Content - ideas of hopelessness & worthlessness, Ideas of guilt, suicidal ideas.

Perception - Normal.

PRIMARY MENTAL FUNCTIONS

Oriented to time, place and person

Attention arousable, Concentration sustained

Memory

Immediate
Recent } intact
Remote

Intelligence

General fund of information - adequate

Abstract thinking - intact

Judgement to test situation - intact

Insight - Grade IV, knows that he has problems in his mind, but is confused how it is caused.

PROVISIONAL DIAGNOSIS:

F 31.4 Bipolar affective disorder, current episode severe depression without Psychotic symptoms

PSYCHOLOGICAL ASSESSMENT

This person was assessed with the following psychological tests Eysenck Personality Questionnaire (EPQ) is also used to assess personality and possible psychotic symptoms.

Multiphasic Person Questionnaire is used to assess psychopathology.

Sentence Completion Test (SCT) was used to elaborate on his attitude towards family, parents, and his interpersonal relationships.

Rorschach Inkblot Test, a projective test of personality used to assess his personality structure and diagnosis

Hamilton Anxiety Rating Scale (HAM-A), is used to assess the severity of anxiety

Hamilton Depression Rating Scale (HDRS) is used to assess the severity of depression

Suicide intent scale is used to assess the intent

Suicide ideation scale is used to assess the severity of the ideas

BEHAVIOURAL OBSERVATION:

She was very co-operative and showed interest but on and off she cried. She had to be repeatedly reassured to continue the tests. She showed sufficient amount of attention and concentration. She talked relevantly-content of talk revealed her depressive mood. She was looking sad. It was appropriate to her mood

TEST RESULTS:

EPQ -she showed elevated scores on neurotism and high lie score with average score on extroversion suggestive of a person of ambivert dimension of personality with emotional inadequacies in her premorbid personality

MPQ - She showed significant amount of depression due to feeling of hopelessness and worthlessness with suicidal rumination & evidence of paranoid tendencies such as being talked about suggestive of having gross psychopathology

Sentence completion test shows significant amount of psychosocial stress in the areas of family & sex. There was evidence of negative cognition, feeling of worthlessness, hopelessness with strong guilt feeling

Rorschach test showed below average range of productivity - had reality touch but not adequate; organizing and synthesizing abilities were poor; emotional reactions were dominated by dysphoric mood with few evidence of colour responses showed her impulsive thinking. There were narrow range of responses which showed her inadequate involvement in pleasurable aspects. Content analysis showed religious pre occupations. Otherwise no evidence of any bizarre or contaminatory responses

Hamilton rating scale for anxiety showed minimal anxiety

Hamilton rating scale for depression showed severe amount of depression in the areas of mood, guilt & suicide. Score is 23

Suicide intent scale -showed significant amount of suicidal rumination with high amount of intention. The score at intent & ideation scale was 21 and 18 respectively

SUMMARY

With these, this patient has premorbidly inadequate personality and has manifested features of major depression

FINAL DIAGNOSIS

F 31.4 Bipolar affective disorder ;current episode severe depression without psychotic symptoms

MANAGEMENT

Pharmacotherapy:

Patient is put on T.Sodium valproate 200 mg thrice daily, T. Sertraline 50 mg twice daily, T. Clonazepam 0.5 mg (2 tabs) at bedtime.

Though role of antidepressants is controversial issue in bipolar depression, patient is treated with antidepressants along with mood stabilizers due to severity of the illness once the patient improves, anti depressants should be tapered and stopped.

Psychotherapy

1. CBT (Cognitive behavior therapy)-patient was educated about the disorder and its treatment, cognitive behavioral skills for coping with stress associated problems.

2. Interpersonal and social rhythm therapy - to reduce the lability of mood by maintaining regular pattern of daily activities
   (eg. sleeping, eating etc)

3. Family therapy - psychoeducation to family members about identifying precipitating stresses inside and outside the family, planning strategies for managing and minimizing future stresses.

PATIENT – 3

Name	:	**Mr. M**
Age	:	20 yrs
Sex	:	Male
Religion	:	Hindu
Education	:	Studying B.Sc.
Socio economic	:	MSES
Informants	:	Self, sister
Information	:	Reliable, Adequate and consistent

PRESENTING COMPLAINTS

Repeated doubts about his activities

Fear of contamination and frequent elaborate washing 2 years

Fear of things going wrong

HISTORY OF PRESENT ILLNESS:

As per the patient, he started having his problems insidiously, beginning with doubts about simple activities like locking a door, counting money etc. He had to check and recheck to satisfy himself. This progressed to irrational thought that his plate would be contaminated and subsequent repeating washing of his dinner plate. He recognized these thoughts as his own and irrational unwanted ones, but he could not control the anxiety associated with this while walking on the road, he felt every bit of paper lying as something very important and he had to open it and check it to make sure of it. He could not cross a door without lifting his feet and slowly crossing it so as not to touch the midline. This he felt

would bring bad luck. All his activities produced significant compensation in his studies and daily activities.

No h/o head injury, seizures, talking to self, hearing voices.

No significant medical or psychiatric illness.

FAMILY HISTORY:

Born of non consanguineous marriage.

No family history of similar illness.

PERSONAL HISTORY:

Both milestones normal.

Student currently in his 2nd year of degree.

PREMORBID PERSONALITY:

Quiet, unassuming, shy, had many friends, religious, conscientious and a perfectionist. Meticulous in his activities.

PHYSICAL EXAMINATION:

General examination WNL

CVS – S1, S2 heard

RS – NVBS heard

Abdomen – Soft, nontender, no organomegaly

CNS – Clinically normal.

BP – 110/70 mm Hg.

Pulse – 80/min

MENTAL STATUS EXAMINATION:

General Appearance: Cooperative, attentive, well kempt.

Psychomotor activity normal

Talk – relevant and coherent. Quantum Tone Rate normal.

Mood (s) Anxious

(o) Anxious

Thought Form, stream normal

Obsessive thoughts about contamination – believes something will go wrong if he does not move about in a specific pattern – Magical thinking +

PRIMARY MENTAL FUNCTIONS

Oriented to time, place and person

Attention arousable, Concentration well sustained

Memory

Immediate
Recent } intact
Remote

Intelligence

General fund of information adequate

Abstract thinking intact

Judgement to test situation intact

Grade V insight.

DIAGNOSTIC FORMULATION:

20 years male presenting with complaints of frequent washing of his plates and fear of contamination, unpleasant and intrusive thoughts, magical

thinking, MSE revealing anxious affect, obsessive thoughts, magical thinking and compulsive acts.

PROVISIONAL DIAGNOSIS:

F 42.2 Obsessive Compulsive Disorder – Mixed obsessional thoughts and acts.

PSYCHOLOGICAL ASSESSMENT:

Mr. K clinically diagnosed as a case of OCD is taken up for psychological assessment to assess his symptom patterns, severity of illness and for personality.

Test administered and their rationale:

Eysenck personality inventory: is used to assess his personality.

Eysenck Personality Questionnaire– is also used to assess personality and possible psychotic symptoms.

Middlesex Hospital Questionnaire (MHQ) consists of various neurotic dimensions.

Sentence Completion Test was used to elaborate on his attitude towards self, family, college, parents, and his interpersonal relationships and also to assess his fears, aims and goals in life

Rorschach test, a projective test of personality used to assess her personality structure and diagnosis

Thematic Apperception Test, a projective test of personality used to assess her interpersonal relationship, goals and conflicts.

Hamilton Anxiety Rating Scale – to assess the degree of anxiety

Yale-Brown obsessive compulsive scale– for rating the severity of obsessions and compulsions.

Montgomery Asberg Scale – To know the depressive state.

Behavioural Observation:

Very good at expressing his problems. Rapport could be established easily.

Test results:

Eysenck Personality Inventory showed he is an ambivert person with severe degree of neuroticism. Low lie scores indicate that he is straight forward with high superego functioning.

Eysenck Personality Questionnaire – His scores on EPQ indicate severe degree of neuroticism with low psychoticism and moderate extroversion.

Middlesex Health Questionnaire He had significantly high scores on all dimensions showing high neuroticism.

Thematic Apperception Test His stories are productive, imaginative and projective of his childhood experience of neglect. He is also neurotic with fear of darkness, loneliness.

Rorschach test he is highly imaginative which at times leads to unwanted thoughts, preoccupations and emotional reactions. He has adequate ego strength inspite of neurotic fears which favours psychotherapeutic interventions.

Y-BOCS AND HDRS– reveal mixed symptoms of obsessions and compulsions with features of anxiety.

Montgomery Asberg Depression Rating Scale shows he has certain amount of depression as a result of his family conflicts and insight into his symptoms.

SUMMARY:

She scored high on various neurotic dimensions on personality indicating that she is highly neurotic in her thoughts, feelings and reactions to the environment with which we can diagnose her as a case of mixed neurosis with obsessive symptoms.

FINAL DIAGNOSIS

F 42.2 Obsessive Compulsive Disorder, Mixed obsessional thoughts and acts.

MANAGEMENT

Pharmacotherapy

SSRI - Fluoxetine 40 mg OD

Psychotherapy

Cognitive Behaviour Therapy –to manage his irrational beliefs and to modify the subsequent unwanted behaviour. Focuses on the obsessions.

Exposure Response Prevention- to manage the compulsions

Thought stopping –to control the obsessive thoughts

PATIENT – 4

Name	:	**Mrs. K**
Age	:	22 yrs
Sex	:	Female
Marital Status	:	Married
Occupation	:	Apprenticeship in chartered accountancy
Religion	:	Hindu
Education	:	B.com
Socio economic	:	MSES
Informants	:	Self & Mother, husband, uncle
Information	:	Reliable, Adequate and Consistent

PRESENTING COMPLAINTS:

Frequent anger outbursts
Breaking household articles
Multiple suicidal threats & attempts
} 1 yr, more for the past 6 months

Insidious onset, continuous illness

HISTORY OF PRESENT ILLNESS:

Mrs.K was maintaining well 1 year back. She was staying alone with her husband. Initially she was asking her husband to bring small things like pen and books when he was in office. Gradually she began demanding costly items like ear rings / diamond pendants. If he didn't buy it for her then and there, she would pick up fight with her husband. Some times she would scream & would break household articles like TV, DVD player, crystal vases. She started saying that she would harm herself if her demands are not fulfilled.

She started showing excessive anger towards her husband for trivial reason.

Sometimes she was abusing her husband with filthy words. When she was asked about this, she told that she was not able to control her & it subsided only after she screamed or broke things. She also said that she would not feel remorse for having broken so many things. She was becoming irregular to work she started disturbing her husband excessively. She wanted everything in the house to happen according to her wish if it didn't happen like that she would threaten to kill herself by strangulating herself ,slashing her wrist ,jumping off the roof.

About 3 months back, she attempted to hang herself after she had fight with her Husband. She was rescued after 2 -3 minutes by her husband and she was taken to a Private hospital. She was seen by a psychiatrist & she was started on T.Diproex ER 500 0-0-1, T.Olanzapine-F ½-0-½ ,T.Stalopam 0-0-1,T.Lithosun SR 0-0-1.

She was on these medication for the past 3 months. However even when on these medications she continued to fight. She lost interest in doing household work like cleaning, washing clothes. She had sleep disturbance also. The intensity of the symptoms has increased.

She frequently threatens to commit suicide and very often makes superficial cuts on her Wrist or tries to strangulate herself during fights in front of her husband. About a week ago following an argument over a trivial matter, she took off all her clothes and began to shout in abusive language, accusing her husband of having an extramarital relationship with her mother and threatened to jump off the 2nd floor of the house. As she was unmanageable at home, she was brought to IMH for further management.

No h/o suggestive of psychotic symptoms

No h/o suggestive of manic adsymptoms

No h/o sad mood,ideas of worthlessness / helplessness / hopelessness, tremor, palpitations

No h/o repetitive thoughts/images/actions

No h/o head injury with loss of consciousness/seizure/substance use

PAST HISTORY

H/o similar episode 2 yrs back which was characterized by anger outburst, abusive behaviour following which she was taken to a private psychiatrist and she was Started on T.Olimet 5 mg 1-0-1, T.Trinicalm forte 0-0-1,T.Trioptal 150 mg 1-0-1. T.Epitril 0.5 mg 0-0-2, T.Pacitane 1-0-1.she however refused to take the medication saying that there was nothing wrong with her.

H/o primary complex at 3 yrs of age

FAMILY HISTORY:

Born of non consanguineous marriage

Father - 48 years old, separated when patient was 6 yrs old

Mother - 38years old, working as a teacher

Patient is first order by birth. She has one younger brother who is healthy

H/o alcohol dependance in her father

H/o suicide in maternal grandmother by hanging

PERSONAL HISTORY:

Early childhood:

Birth and milestones were normal.

Middle childhood:

Started schooling at the age of 5 yrs. Bright in studies.She witnessed her father's abusive & assaultive behaviour towards her mother. He separated from her mother when she was 6 yrs old. Since then due to financial difficulties,she has been staying with different relatives for variable periods of time

Late childhood :

She continued her studies in different schools as she was disobedient and irregular. She had very few friends in school. she was very sensitive to criticism. There were no h/o stealing/lying/truancy.

After 12^{th} std,she has joined B.com through correspondence

Mensrual history :

Attained menarche at the age of 14 yrs.Regular periods.

Adulthood:

After she finished B.com,she did CA foundation course. Then she started to work as Apprentice.

Marital history :

Married since 1 yr 3 months. Husband is 20 yrs elder than her.she is a 3^{rd} wife. She fell in love with him and threatened him to marry her. Marital disharmony present.

Sexual history :

She had satisfactory sexual relationship with her husband

PREMORBID PERSONALITY

Introvert, sensitive to criticism, had feeling of chronic emptiness, manipulative, would indulge in self injurious behaviour, had low frustration tolerance lability of mood, had difficulty in sustaining very close relationships, not responsible, had attention seeking behaviour, interested in painting and singing not much religious

PHYSICAL EXAMINATION:

Moderately built

Not anaemic, jaundiced

No pedal edema, lymphadenopathy,thyroid swelling

BP – 110/70 mm Hg.

PR – 80/min, regular

CVS – S_1, S_2 heard.

RS – NVBS heard.

Abdomen – Soft, nontender, no organomegaly

CNS – Clinically normal.

Fundus – Normal

MENTAL STATUS EXAMINATION:

General Appearance and Behaviour: Conscious, ambulant, In touch with surroundings. Dressed adequately, well kempt, gaze contact sustained, Co-operative, Rapport established. No tics or mannerisms.

Psychomotor activity – normal

Talk - Quantum, Rate and Tone - Increased, Reaction time normal, Relevant and Coherent.

Mood - (s) she feels happy

(o) labile

Thought – Form and stream - Normal

Content - no delusions, no suicidal ideas.

Perception - Normal.

PRIMARY MENTAL FUNCTIONS

Oriented to time, place and person

Attention arousable, Concentration -sustained

Memory

Immediate
Recent } intact
Remote

Intelligence

General fund of information - adequate

Abstract thinking - intact

Judgement to test situation - intact

Insight - Grade IV, knows that she has problems in his mind, but is confused how it is caused.

PROVISIONAL DIAGNOSIS:

F60.3 Emotionally unstable personality disorder

F60.31 Borderline type

PSYCHOLOGICAL ASSESSMENT

Patient was assessed for personality and psychodynamic aspects

Tests administered

1. EPQ (Eyesenck Personality Questionnaire) ,
2. 16 PF (sixteen personality factor)
3. Bell's adjustment inventory
4. Sentence completion test,
5. TAT (Thematic Apperception Test),
6. SSI (Symptom & Sign inventory),
7. HAM-D (Hamilton rating scale for depression)
8. YMRS (Young Mania Rating Scale)
9. Rorschach test

Behavioural Observation :

Eye contact maintained. Rapport established. Attention could be aroused and sustained. She was able to comprehend instructions.

TEST FINDINGS:

Patient who is of average intelligence with good visuo - perceptual gestalt Functions.

PERSONALITY:

The patient is more towards introvert tendency with high lie score on EPQ but on 16 PF it was low. She scores low on factor c -tends to be low in frustration tolerance ,changeable & plastic evading necessary reality demands, neurotically fatigue, fearful, easily emotional & annoyed, active in dissatisfaction she is unsteady in purpose & often causal &lacking in effort for

group undertakings & cultural demands. She is low on ego integration & may feel mal adjusted & have many mal adjustments especially of an affective type. High tension level may disrupt work performance

INTERPERSONAL:

Average on home adjustment. Very poor adjustment on emotional & social areas & unsatisfactory on health area. Need for achievement & need for affection is being projected and almost all themes on TAT was on family, parent child separation, marital separation, uncertainty of the future, realisation of the mistake by the main character of the story and optimistic end. Negative attitude towards family & father figure with lot of interpersonal conflicts projected on SCT.

Rorschach test : total response :11 with average mentation time.6 popular & 5 originals with good form level rating. Content analysis shows animal & human responses.

SSI : Scores are not elevated

HAM-D : Does not show any depressive symptoms

YMRS : There is no significant score

SUMMARY:

Patient with adequate cognitive function with an inadequate emotionally unstable personality with poor emotional control with no evidence of psychosis

FINAL DIAGNOSIS:

F 60.3 - Emotionally unstable personality disorder

60.31-Borderline type

MANAGEMENT :

PHARMACOTHERAPY :

Patient is treated with

1) T.Carbamazapine 200 mg thrice daily

2) T.Lorazepam 2 mg at bed time

PSYCHOTHERAPY:

Reality oriented approach was effective in this patient.

Behavior therapy was used to Control patient's impulses & angry outbursts and to reduce their sensitivity to criticism and rejection.

Social skills training was also given to the patient

DBT (Dialectical Behavior Therapy) was tried to

1. Enhance & expand the patient's repertoire of skillful behavioral patterns
2. Improve patient motivation to change by reducing reinforcement of mal adaptive behavior including dysfunctional cognition and emotion
3. Ensure that new behavioral patterns
4. Structure the environment

PATIENT – 5

Name	:	**Mr. D**
Age	:	38 yrs
Sex	:	Male
Marital Status	:	Unmarried
Occupation	:	unemployed
Religion	:	Hindu
Education	:	10^{th} std
Socio economic	:	LSES
Informants	:	Father & Mother
Information	:	Reliable, Adequate and Consistent

PRESENTING COMPLAINTS:

Suspiciousness
Sleep disturbance
Wandering behaviour } initial 6 ½ yrs
Talking & laughing to self
Poor self care

H /O whereabouts not known - next 5 ½ yrs

Not able to recognize his family members
Making gestures } - 3 weeks

HISTORY OF PRESENTING ILLNESS:

Patient was apparently normal 12 yrs back. He was regular to work. He seemed to be interested in black magic which was practiced by his grand father

his interest in black magic had increased gradually after his grand father's death. He was pre occupied with ideas of black magic and started talking excessively about black magic. Slowly he began to believe that someone had done blact magic against him to prevent his progress in life. Sometimes he suspected his mother had mixed poison in his food & he refused to take food served by her. Sometimes he had suspicious ideas towards his father. When his parents enquired about this. He never replied. When they tried to convince him, he never got convinced. This was present daily and continuously.

He started having sleep disturbance due to repeated preoccupation with ideas of black magic in the form of frequent awakenings. He slept for about 5 hrs per day.

Simultaneously he started wandering aimlessly in the streets. Sometimes he spent time in temple by sitting idly. whenever he was questioned about this behaviour, he became irritable .he was found talking & laughing to self also sometimes.

He was not maintaining his personal hygiene. He had to be persuaded to do so.

Gradually the intensity of the symptoms has increased and he started assaulting his parents for no reason. As his behaviour was unmanageable,he was brought to IMH after 1 yr of onset of symptoms. He was treated with antipsychotics and ECT. symptoms improved. He didn't attain the premorbid level of functioning He discontinued the treatment after 6 months. He started having symptoms. He was on irregular treatment till 2002.he got admitted many times in IMH till 2002.few days after his last admission ,he absconded from the home. History of whereabouts was not known for the next 6yrs.3 weeks back, patient was found and brought home. He couldn't identify his family members, friends, neighbours.

At home, he made gestures. He spoke in incomprehensible way. He had sleep disturbance in the form of frequent awakenings. He was not maintaining his personal hygiene. He often tried to go out of the house.as his behaviour was unmanageable at home, he was brought to IMH 10 days after the onset of symptoms.

PAST HISTORY:

No significant psychiatric or medical illness

FAMILY HISTORY:

Born of non consanguineous marriage. History of psychiatric illness in paternal grandmother. History of suicide in his cousin

PERSONAL HISTORY:

Birth history normal

Developmental mile stones were normal

Poor scholastic performance

unmarried

No h/o substance abuse

No h/o sexual contact

PREMORBID PERSONALITY :

Introvert, adjustable, responsible

PHYSICAL EXAMINATION:

Moderately built

Not anemic, no icterus

No cyanosis, no pedal edema

BP :110/80 mmHg

PR : 84/m

SYSTEM EXAMINATION:

CVS -S1,S2 heard

RS - normal vesicular breath sounds

ABD - soft, no organomegaly

CNS - no focal neurological deficit

FUNDUS -normal

MENTAL STATUS EXAMINATION :

General appearance and behavior, attitude

Ambulant, clean and kempt, dressed adequately. looking indifferent to the Surroundings. gaze contact was not maintained. He was looking around the examination room. He tried to leave the examination hall. Rapport not established.

Psychomotor activity : increased

Attitude : partially co operative ,not interested in examination

Stereotypical movements noted at times. no tics/posture/rigidity

Speech : Relevant to very few questions asked.irrelevant and incomprehensible most of the time. Reaction time-normal, Tone and volume - normal, dysprosody present

Mood : Euthymic

Affect :Inappropriate

Thought :

Stream-normal

Form -loosening of association present

Content -no delusions could be elicited

Perception:

No perceptual disturbances

Primary Mental Functions:

Conscious, not oriented

Attention -impaired ,concentration -ill sustained

Memory :

Short term memory -impaired

Long term memory -impaired

Intelligence :

General fund of information : inadequate

Calculation ability is impaired

Abstract thinking is impaired

Judgement :

Hypothetical situation - impaired

Social judgement - impaired

Insight : absent (grade 1)

Lobar Function Test:

Impairment in frontal ,temporal and parietal lobe function

Investigations :

Blood investigations - normal

EEG -normal

CT Brain -?hypo density in right occipital lobe

MRI Brain - Bilateral postero-medial occipital & parietal lobes symmetrical cortical sub cortical T1 hypointense and T2 hyper intense signal focal gliosis

Changes. ?sequalae of perinatal hypoxic ischemic injury. ?post traumatic sequalae

Provisional diagnosis :

DD : 1) F 09 Unspecified organic mental disorder

2) F 20.3 Undifferentiated schizophrenia

Psychological Assessment

Mr.D , 38 yrs old male was assessed with following psychological tests.

Tests administered :

1. MINI MENTAL STATUS EXAMINATION
2. BPRS (Brief psychiatric rating scale)
3. PANS
4. GLOBAL ASSESSMENT OF FUNCTIONING

Behavioural observation :

Formal testing was not possible due to uncooperativeness. He was looking restless. He was able to sit for short time & was able to give answer to simple questions. His attention could be arousable but concentration was ill sustained.His talk was irrelevant most of the time.

Test Findings :

MMSE -Patient scored 8 out of 30.it shows that he has global impairment in areas of orientation,registration,recall functioning,calculation suggestive of definite brain damage

BPRS-showed conceptual disorganisation, blunted affect,

Emotional withdrawl, mannerisms & posturing suggestive of gross psychopathology in severe amount.

PANS - showed more of negative symptoms in the areas of ability to feel intimacy & closeness,relationship with friends and family members,recreational interest & activities GAF-showed severe impairment in several areas such as work, family Relations,judgement,thinking,mood,communication

Impression :

This patient has severe amount of cognitine impairment especially in the areas of orientation, registration, recall, calculation ability, intelligence. pt also has features of chronic schizophrenia

Final Diagnosis:

F 09 -Unspecified organic mental disorder

Management:

Pharmacotherapy

Patient is treated with 1) T.Quetiapine 25 mg twice daily

2) T.Lorazepam 2 mg at bed time

Dose of quetiapine has been stepped up.

Others

Family Education :

The nature of illness and importance of treatment was explained to patient's family members. They were taught how to behave with him & handle him at home in a proper way.